APPENDIX 6 PRIOR AUTHORIZATION REQUEST FORM (PA/RF) SAMPLE

MAIL TO:				PRIOR AUTHORIZATION REQUEST FORM						
E.D.S. FEDERAL CORPORATION				DA (DE				1 PROCESSING TYPE		
PRIOR AUTHORIZATION	N UNIT			PA/RF (DO NOT WE	RITE IN THIS SPAC	CE)				
6406 BRIDGE ROAD				ICN #						
SUITE 88								129	1	
MADISON, WI 53784-00	288			DA #						
2 RECIPIENT'S MEDICAL ASSIST	TANCE ID NU	IMBER		1234567	A DECIDIENT	ADDRESS (STREET	CITY CTATE	7ID CODE		
1234567890								AP CODE)	l.	
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)										
Recipient, Im A. Anytown, WI 55										
5 DATE OF BIRTH			6 SEX	M F _X	8 BILLING PR	OVIDER TELEPHONE	NUMBER			
MM/DD/YY 7 BILLING PROVIDER NAME, AD	DDEGG 71D		<u> </u>	<u> </u>	(xxx) xxx - xx				
/ BILLING PROVIDER NAME, ALI	DRESS, ZIP (CODE:				9 BILLING PROVIDE 76543210	R NO.			
								,		
I. M. Provider 1 W. Williams 1 Would in the state of the								schizophrenia		
Anytown, WI 55555 11 DX: SECONDA										
,,, -							passive aggr. person			
						12 START DATE OF			IRST DATE RX:	
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PROCEDURE CODE	MOD	16 POS	TOS	18 DESCRIPT	TON OF SERVI	CF.	19 QR	20	CHARGES	
	+	<u> </u>					4,1		OTANGES	
W8911	İ	3	1	Day Treatment			10		VVV VV	
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00 An annual authorist		ــــــــــــــــــــــــــــــــــــــ	·				TOTAL	21		
22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the									XXX.XX	
recipient and provider at	the time	the ser	vice is t	provided and the comple	eteness of th	ne claim informa	tion Payro	ent will	not be made	
tor services initiated prior	to approv	/al or aft	er autho	orization expiration date.	Reimburseme	nt will be in acc	omlance w	ith Wicc	onein Madical	
Assistance Program paymauthorized service is provide	ient metri ded. WMAI	odology Preimbu	and Po rsement	IICY. If the recipient is will be allowed only if the	enrolled in a	Medical Assist	ance HMO	at the	time a prior	
	200, 11112	10111100	- Conton	will be allowed only it tik	S SCI VICE IS IIU	it covered by the	HMU.			
23 MM/DD/YY			ی جی	to Puil	,					
23 PATE DATE		- 24		EQUESTING PROVIDER SIGNATURE						
				(DO NOT WRITE IN TH	IS SPACE)					
AUTHORIZATION:				(DO NOT WHITE IN THE	IS SPACE)					
	-			PROCEDURE(S) AUTHORIZED QUANTITY AUTHORIZE					TY AUTHORIZED	
APPROVED		GR	ANT DATE	EXPIRATION	DATE					
MODIFIED - RE	ASON:									
DENIED - REA	ASON:									
RETURN - RE/	ASON:									
, 14, 101 11 — ME/	~ ○14.									
DATE				IOI II TRAFT (ANIA) SIGN	·	 	_			
482-120 DATE			CON	NSULTANT/ANALYST SIGNATUR	Œ					